NOTE: This is a sample pain management agreement offered by the Iowa Board of Medicine for physicians who prescribe controlled substances to patients with chronic pain. Iowa Administrative Rule 653—13.2(5)"g" encourages physicians to use agreements that specify the use of pain control medications and the consequences for misuse.

PAIN MANAGEMENT AGREEMENT

1. **PURPOSE:** The purpose of the Pain Management Agreement (Agreement) is to prevent misunderstandings about certain controlled medications you will be taking for pain management. This is to help both you and your physician (provider) to comply with the law regarding controlled medications. I understand that this Agreement is essential to the trust and confidence necessary in a physician/patient relationship and that my physician undertakes to treat me based on this Agreement.

2. **VIOLATION:** I understand that if I break this Agreement, my provider will stop prescribing these pain control medications, and may terminate my care. In this case, my provider may choose to taper me off of my medications, or discontinue medications and prescribe medication to treat the withdrawal symptoms. This choice will be made my provider.

3. **COMMUNICATION:** I will communicate fully with my provider about the character and intensity of my pain, the effect that my pain has on my daily life, and how well the medications are helping to relieve my pain.

4. **ILLEGAL DRUGS PROHIBITED:** I will not use illegal drugs, including marijuana, heroin, cocaine, etc.

5. **DRUG DIVERSION PROHIBITED:** I will not share, sell or trade my medications to anyone. Altering a prescription in any manner, selling medications, or misrepresenting myself to a pharmacy is a felony and will be reported to the police.

6. **SINGLE PROVIDER:** I will not attempt to obtain controlled medications, including opioid pain management medications, controlled stimulants, or anti-anxiety medications from any other physician.

7. **PROTECTING MEDICATIONS:** I will safeguard my medications from loss or theft. Lost or stolen medications **will not** be replaced. To reduce instances of medication loss/theft, carry only the amount of medications that you will be using when away from home.

8. I agree to use the following pharmacy for all of my pain control medication prescriptions:

_____

(PRINT NAME OF PHARMACY, ADDRESS, AND TELEPHONE NUMBER.)

9. **REFILLS:** I agree that requests for renewals of my prescriptions for pain control medications will be made at the time of an office visit or during regular office hours of my provider. If you fail to come to a scheduled appointment without notifying us **prior** to that appointment you will not be given a refill until you are seen. **No renewals will be available under any circumstances during the evenings or on the weekends.**

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10. **PERMISSION TO CONTACT PATIENT REFERENCES:** I agree that my provider or authorized staff member may contact one or more of the references I have provided on a separate form to discuss my history and medical care at any time during the course of my treatment.

11. **PERMISSION TO CONTACT PREVIOUS PHYSICIAN AND PHARMACY:** I agree that my provider or authorized staff member may contact my previous physician(s) and/or my previous pharmacy to discuss my history and medical care at any time during the course of my treatment.

12. **PRESCRIPTION MONITORING PROGRAM:** I am fully aware that my provider may review my controlled substance prescription records in the Iowa Prescription Monitoring Program operated by the Iowa Board of Pharmacy at any time during the course of my treatment to determine whether I have obtained prescriptions from other providers.

13. **COOPERATION WITH INVESTIGATIONS:** I authorize the provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the State Board of Pharmacy in the investigation of any possible misuse, sale, or other diversion of my pain control medications. I authorize my provider to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right or privacy or confidentiality with respect to these authorizations.

14. **DRUG TESTING:** I agree to submit to a blood or urine test **at my cost** if requested by my provider to determine my compliance with my program of pain control medications. Refusal to submit to this test will result in the **immediate termination of my care** by the provider.

15. **MISUSE OF MEDICATIONS:** I agree that I will use my pain control medications at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medications for a period of time. Continued misuse of pain control medications will result in termination of my care from this provider.

16. **HOSPITALIZATION:** If you are hospitalized while under the care of the provider and have questions for our providers, your hospital nurse taking care of you will call the clinic. You are not to call the clinic when you are hospitalized.

17. **UNDERSTANDING THIS AGREEMENT:** I agree that all terms of this Agreement have been fully explained to me and I understand all terms of this Agreement. All of my questions and concerns regarding treatment have been adequately answered. Copies of this signed Agreement will be given to me and placed in my medical record.

THIS AGREEMENT IS ENTERED INTO ON THIS DATE: _____

PATIENT SIGNATURE: _____

PROVIDER SIGNATURE: _____

WITNESSED BY: _____

REVISED: April 2012.